TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Cy-Fair Pain Solutions

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-15-2456-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Regarding DOS: 5/15/14 (99358)

Reason For Denial. Service not covered and original payment decision maintained

Initially this DPS was denied initially do to Invalid Dr. State License #. I provided a copy of a valid state license #. J3719

I provided the requested information and the description of procedure necessary for payment.

On 8/15/14 payment was denied for the fact that service is not covered and the IC original payment decision is being maintained.

On 10/24/14 IC denying payment as this is not a covered service. This is not the case. Physicians every day bill for this services. I have been providing this services to patient thatv this evaluation and management services is necessary. I have billed this type opf service when necessary and have been paid for this services as well as other physicians on a ddaily bases. The CPT code guidellings specificall had a code for this services and this services is exactly what I performed. I am pad on this type of services when performed.

This denial has no validity as the necessary medical service is necessary for the medical management and necessity for providing medical services to this patient. In this case for DOS 5/15/14 the medical file was pull and documents were copied in order to send in for physician review for authorization for services for this patients treatment.

On 11/18/14 I filed a RFR and have not received a response."

Amount in Dispute: $125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "AIG has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). In reviewing the report, it is the carrier's position that in accordance with Medicare Fee Schedule, Medicare notes the following:

'*Medicare contractors will not pay (nor can providers bill the patient) for prolonged services codes **99358** and 99359, which do not require any direct patient face-to-face contact (e.g., telephone calls). These are Medicare covered services and payment is included in the payment for other billable services.'*

Therefore, in accordance with the Medicare and state fee schedule, the carrier has denied payment for the above CPT code correctly."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2014	Prolonged evaluation and management service, Before and/or after direct patient care (99358)	$125.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - VA07 – This service/supply is not covered according to the state fee schedule guideline.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - VM12 – Our position remains the same. We have received no documentation that would alter our original recommendation.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code VA07 – "This service/supply is not covered according to the state fee schedule guideline." 28 Texas Administrative Code §134.203 (b) states, "For coding, billing, reporting, **and reimbursement** of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules" [emphasis added].

   Review of the submitted information finds that the requestor is seeking reimbursement for CPT Code 99358. Medicare lists this code as status "B – Bundled Code, Payment for covered services are always bundled into payment for other services not specified." The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	May 27, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.